

UTAH UNIVERSAL INDIVIDUAL APPLICATION

Please use ink and print legibly

I. APPLICANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ Unit# _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

City _____ State _____ ZIP _____

Street Address (If different) _____

City _____ State _____ ZIP _____

Your Employer _____ Your Group Carrier _____

Your Occupation _____ # of hrs worked _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Group Carrier _____ Spouse's Occupation _____ # of hrs worked _____

E-mail Address _____ Home Ph# () _____ Work Ph# () _____

Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Re-apply

II. APPLICANT AND DEPENDENT INFORMATION

In the section below, list yourself and all eligible family members to be included under medical coverage.

Relationship	Name (First, Middle Initial, Last)	Social Security # (For Internal Use Only)	Gender	Birth Date (MM/DD/YY)	Height	Weight
Self						
Spouse						
Child						
Child						
Child						
Child						
Child						
Child						
Child						
Child						

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, **children must be under the age of 26, unmarried, and dependent upon you** for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

III. DUAL COVERAGE/COORDINATION OF BENEFITS INFORMATION

For Dual Coverage/Coordination of Benefits purposes, indicate each individual who will also be covered by other medical insurance while this coverage is in force. Please do not complete this section if other coverage will be terminated once this coverage is in force.

Relationship	Names of Individuals Covered by Other Insurance	Carrier Name	Carrier Ph#	Policy #	Effective Date

IV. AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FOR PRE-ENROLLMENT UNDERWRITING PURPOSES

By signing this form, you give a carrier the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). A carrier typically gathers both paper and electronic records. This information helps a carrier make an educated decision about insuring you and your dependents.

A. Authorization

I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to a carrier for purposes of determining my eligibility for health insurance coverage as requested in this application. The medical information I authorize to be disclosed includes any medical information related to my insurability, except for any private genetic information about me or a blood relative of mine. (Utah law prohibits insurers from using private genetic information for underwriting purposes.)

B. Information for Applicant and Dependents

I understand the following information:

1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in a plan by sending my written request to the carrier; however, if I do so the carrier may refuse to enroll me;
2. A health care provider may not condition my treatment on signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. I understand that the information the carrier receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information.
5. If the carrier does not enroll me, it may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law. (If the carrier denies insurance coverage because of an individual's health condition, Utah law requires the carrier to tell the applicant specifically what this health condition is);
6. If the carrier does enroll me, it will only use information disclosed under this Authorization for purposes described in its notice of privacy practices;
7. Unless revoked, this Authorization will remain in effect for underwriting purposes until 60 calendar days from the date the carrier has approved or rejected this application.

C. Identifying Signatures for Applicant and Dependents 18 years of age or older

Applicant	Date of Birth	Applicant signature*	Date Signed
Spouse	Date of Birth	Spouse signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed
Child	Date of Birth	Child signature or representative with legal authority*	Date Signed

* Generally, spouses and children 18 years of age or older must sign for themselves.

V. HEALTH INFORMATION

Instructions: Answer each question considering each individual applying for medical coverage. Circle any specific item(s) in the question that applies. Give complete and specific details in Sections VI and VII for each "Yes" (Y) answer.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the carrier of any change in health status while application is pending.

Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO
1	Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			28	Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease?		
2	Are you or your spouse pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			29	Infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births), or any other disorder of the reproductive system?		
3	To the best of your knowledge, has any applicant been denied health or life insurance or been issued a modified or rated policy?			30	Varicose veins, or any other circulatory disorder?		
Within the past 12 MONTHS has any applicant:		YES	NO	31	Foot, knee, or bone disorder?		
4	Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			32	Fracture or dislocation?		
5	Had a health condition, problem, or disorder for which medical advice or treatment has not been sought?			33	Tobacco use (chewing or smoking)?		
6	Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			34	Condition for which hospitalization, tests, consultation, evaluation, surgery, or medication <u>have been advised, but not completed</u> ?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	35	Inability to work or to perform routine daily functions for more than 2 weeks (other than pregnancy)?		
7	Physical, neurological, or neuromuscular impairments?			Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
8	Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions?			36	Alcohol use/abuse, been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption?		
9	Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication?			37	Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?		
10	Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			38	Crohn's disease. Colitis, colostomy, or ileostomy?		
11	Eyes, ears, nose, sinus, or throat disorder?			39	Lupus, gout, arthritis, fibromyalgia, or scleroderma?		
12	Jaw disorder?			40	Cysts?		
13	Allergies, hay fever, or adverse drug reactions and side effects?			41	Drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
14	RSV, reactive airway disease, lung disease, or any other respiratory system disorder?			42	Hospitalization or surgery?		
15	Thyroid disorder, goiter, or any other lymph system disorder?			43	Stomach stapling, gastric bypass, or any surgical services for obesity?		
16	Breast lumps, breast augmentation, or breast reduction?			44	Tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
17	Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
18	Back, neck, spinal, or joint disorder?			45	Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
19	Connective tissue disorder?			46	Birth defect, premature birth, development or learning disability, mental impairment, Down syndrome, or autism?		
20	Hemophilia, anemia, blood or bleeding disorder?			47	Cancer (including skin cancer) or tumors?		
21	Obesity, bulimia, anorexia, or any other eating disorder?			48	Cirrhosis or hepatitis?		
22	Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			49	Diabetes (type I or II)?		
23	Hemorrhoids, polyps, or any other rectal disorder?			50	Heart murmur, heart attack, bypass surgery, blood clot, stroke, heart surgery, or coronary artery disease?		
24	Impotence, prostate or testicular disorder, or abnormal PSA?			51	Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
25	Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, or any other gallbladder or digestive disorder?			52	Joint replacement?		
26	Bladder or urinary disorder, or incontinence?			53	Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
27	Sexually transmitted diseases?						

IF ANY OF THE ABOVE CONDITIONS OR QUESTIONS ARE CHECKED "YES" EXPLAIN IN THE SPACE PROVIDED ON THE FOLLOWING PAGE

VI. ADDITIONAL INFORMATION

Question#	First name of individual	Diagnosis of illness, injury, treatment, testing or medical attention	Date began (mm/dd/yy)	Date ended (mm/dd/yy)	Resolved/ongoing	Name and phone# of physician or hospital

Attach additional sheet as needed.

VII. PRESCRIPTION MEDICATION INFORMATION

First name of individual	Name of medication	Dosage	Date began (mm/dd/yy)	Date ended (mm/dd/yy)	Reason for medication	Name and phone # of prescribing physician

VIII. GENERAL INFORMATION

1. Is any employer reimbursing or paying for any portion of this coverage? Y / N
 2. Are you self-employed? Y / N
 2a. If self-employed, do you have any full or part-time employees?Y / N
 3. Does any listed proposed insured live, reside, work, or attend school outside the state of Utah at any time during the year? % of timeY / N
 Please explain "Yes" answers to the above questions. _____

IX. PRIOR COVERAGE INFORMATION

Have you had health insurance coverage within the past 63 days? ☐ Yes ☐ No

If "Yes," list carrier information below. If you answered "No," when was the last date you were insured? _____

If you have had continuous health care coverage not separated by a break in coverage of 63 days or more, your pre-existing condition limitation may be partially or completely waived. To determine if this applies to you, you must enclose proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. You must also provide the following information:

Policyholder's Name _____ Carrier's Name _____

Family Members Covered _____

Policy Number _____ Effective Date _____ Termination Date _____

Carrier's Address _____ Carrier's Phone Number _____

If you were previously insured on a group plan, have you exhausted your COBRA rights? ☐ Yes ☐ No ☐ Not Available

If "Yes," please list dates: Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? ☐ Yes ☐ No ☐ Not Available

If "Yes," please list dates: Date Started _____ Date Ended _____

(COBRA and Utah mini-COBRA rights are your rights to continue group health coverage.)

Have you ever been or are you currently insured through the Utah comprehensive health insurance pool (HIPUtah)? Yes No

If "Yes," please list dates: Date Started _____ Date Ended _____

Submission of prior coverage information does not automatically waive any pre-existing condition limitation. However, failure to provide prior coverage information will result in an automatic 12-month pre-existing condition limitation.

Attach additional sheet as needed.

X. AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, carrier and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the coverage is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or carrier representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the carrier changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the coverage for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages three and four of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the carrier.

XI. SIGNATURE OF APPLICANT AND SPOUSE

Signature _____ Date Signed _____

Spouse's Signature _____ Date Signed _____
(Required if applying for coverage)

Requested Effective Date _____

Coverage is not in force until the carrier approves your application and determines the effective date.

XII. PRODUCER AGREEMENT (If Applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of a carrier; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ Agency _____ Phone _____

Producer Sign and Date Here

Producer Signature _____ Date Signed _____